MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03818

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 1/16/47 (4 mo., 6 days)

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? Since 1/16/47 (4 mo. 6 days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Austin Andrews

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Elizabeth ? Bowersox

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 2/13/1900

8. AGE: Years	Months	Days	If less than one day
47	3	9	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Postmaster

11. Industry or business

FATHER 12. Name: ? Alfred E. Andrew

13. Birthplace: ? Aberdeen Md

MOTHER 14. Maiden name: ? Nina L. Osborn

15. Birthplace: ? Aberdeen Md

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26-1947 (month) (day) (year)

Cemetery or crematory: Baker's

Location: Aberdeen Md

18. Funeral director: Henry Tanning Sons.

Address: Aberdeen Md

19. May 24 1947 (Date rec'd by registrar) C. Henry Tanning Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1947, at 2 25 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/16 1947, to May 22 1947

and that I last saw him alive on May 22 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Just Prior to 1/47
Due to	
Due to	
Other conditions: Schizophrenia, catatonic type	16 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 5-22-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

038177

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME D Franklin Armacost — **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S.

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 5 - 1872

8. AGE: Years 74 | Months 5 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Retired farmer
11. Industry or business

FATHER
12. Name: John A Armacost
13. Birthplace: Md

MOTHER
14. Maiden name: Ruth A J Houck
15. Birthplace: Md

16. Informant: Mrs Hattie Armacost
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 27/47 (month) (day) (year)
Cemetery or crematory: Hampstead
Location: Carroll Co Md
18. Funeral director: Edw A Tipton
Address: Hampstead Md

19. May 27 1947 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1947, at C.A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1941, to May 24 1947 and that I last saw him alive on May 23 1947

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to: Generalized Arterio-Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Edgar M. Bush M.D. M. D. or other
Address Hampstead Md Date signed 5/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03820

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 1 day
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ANNIE MAE BALLARD

3.(b) Social Security Number: 215-16-3803

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 26, 1923

8. AGE: Years: 24 | Months: 2 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Copesbury, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: James Ballard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maggie Merrill
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1947 (month) (day) (year)
Cemetery or crematory Unionville Cemetery
Location Pocomoke, Md.

18. Funeral director H. Harvey Bradshaw
Address Pocomoke, Md.

19. 5/12 (Date rec'd by registrar) 19 47 Albert R. Smith Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 19 47, at 6.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11, 19 47, to May 12, 19 47 and that I last saw her alive on May 12, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1st 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben H. Fuman, M.D. M. D. or other
Address Henryton, Md. Date signed 5/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

Ballard

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03821

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years, 11 months, 16 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 8 years, 11 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 723 St. Paul Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JULIA BERNSTEIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	widowed

6.(b) Name of husband or wife: unknown Max Bernstein

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October, 1887 (date unknown)

8. AGE: Years	Months	Days	If less than one day
59	7		hrs. min.

9. Birthplace: New York City
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Friedman
13. Birthplace: Austria

MOTHER
14. Maiden name: Bertha Pressler
15. Birthplace: Austria

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18, 1947 (month) (day) (year)

Cemetery or crematory: Kings Park Cem.

Location: Long Island, N. Y.

18. Funeral director: Jack Lewis, Inc.

Address: 2106 Eutaw Place, Balto. Md.

19. May 17 1947 (Date rec'd by registrar) C. Harry Eberly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16th 1947, at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1st 1942, to May 16th 1947 and that I last saw her alive on May 16th 1947

Immediate cause of death	DURATION
Polycythemia vera (massive hemorrhages)	11 years
Due to:	
Due to:	
Other conditions: Manic-depressive psychosis	12 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Irene H Lehmann M.D.
M. D. or other

Address: Springfield State Hospital Date signed: 5-16-47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03822

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH:

County Carroll

City or town Middleburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town middleburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Anna A. Biddinger

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Oliver Biddinger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1862

8. AGE: Years	Months	Days	If less than one day
85	3	12	..... hrs. ..... min.

9. Birthplace Frederick County, Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Samuel F. Harbaugh

13. Birthplace Md

MOTHER 14. Maiden name Mary E. Anders

15. Birthplace Md

16. Informant Miss Carrie E. Harbaugh

Address Middleburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16, 1947 (month) (day) (year)

Cemetery or crematory ~~Mt. Zion Heights~~ Mt. Hope

Location Woodsboro ~~Ladiesburg~~, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. May 15 1947 (Date received by registrar) Fanny M. Fries Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28 1946 to May 13 1947 and that I last saw h... alive on May 12 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE D. H. Legg M. D. or other

Address Union Bridge Date signed 5-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03823

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs; 6 Mon.; 9 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3938 Edmondson Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Henry Mortimer Blankenship

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 21, 1868

8. AGE: Years	Months	Days	If less than one day
78	4	28	hrs. min.

9. Birthplace: Richmond, Virginia
(Town, county, and state)

10. Usual occupation: chief clerk, motive power div.

11. Industry or business: B & O Railroad

FATHER
12. Name: Thomas Henry Blankenship
13. Birthplace: Richmond, Virginia

MOTHER
14. Maiden name: Letitia Jane Crawford
15. Birthplace: Richmond, Virginia

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: 5-20-47 (month) (day) (year)

Cemetery or crematory:

Location: Balto. Md.

18. Funeral director: John A. Mitchell & Sons

Address: 1960 Eutaw Place

19. May 20 1947 C. Harry Weed
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19th 1947, at 9.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to May 19 1947 and that I last saw him alive on May 18 1947

Immediate cause of death	DURATION
Senility	9 yrs.
Due to:	
Due to:	
Other conditions: Paranoid condition (arterio-sclerosis) (Include pregnancy within 3 months of death)	41 yrs.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robt Bertrand May M.D.
M. D. or coroner

Address: Sykesville Md. Date signed: 5/19/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03824

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs 4 mos 2 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 707 Park Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ruth Blum

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Herman Blum

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) July 24 - 1888

8. AGE: Years 58 Months 9 Days 30 If less than one day hrs. min.

9. Birthplace United States (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

FATHER 12. Name Max Green

FATHER 13. Birthplace Lithuania

MOTHER 14. Maiden name Ida Green

MOTHER 15. Birthplace Lithuania

16. Informant Herman Blum

Address 707 Park Ave Baltimore

17. Burial Date thereof 5-25-47 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hebrew Friendship

Location Balto. Md.

18. Funeral director Jack Lewis, Inc.

Address 210 Eutaw Place

19. May 23 1947 (Date rec'd by registrar) C. Henry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23d 1947 at 3-35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1943 to May 23 1947 and that I last saw h[illegible] alive on May 23 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs
Due to Organic Brain Disease	5 yrs
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Gaston M.D. M. D. or other

Address Sykesville Md. Date signed 5-23-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1952

03825

CERTIFICATE OF DEATH

Reg. Dist. No. 77

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John Kenneth Boerner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 28-1930

8. AGE:

Years	Months	Days	If less than one day
16	8	16	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Student
11. Industry or business: High School

FATHER
12. Name: John Jacob Boerner
13. Birthplace: Md

MOTHER
14. Maiden name: Gladys M Demmert
15. Birthplace: Md.

16. Informant: J-J Boerner.
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17-47 (month) (day) (year)
Cemetery or crematory: St Paul's
Location: Balto co. Md
18. Funeral director: Edw E Tipton
Address: Hampstead Md

19. May 15 1947 John S. Hughes Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1947 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1947, to May 14 1947
and that I last saw h.. alive on May 14 1947

Immediate cause of death	DURATION
Hemorrhage into Medulla	15 min.
Due to Blow of soft Ball over brain of Brain	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide~~, or ~~homicide~~ Date of 5-14-47
Where did injury occur? Hampstead (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) High School Ball Ground
Means of injury Struck by soft Ball Injured at work? Play

23. SIGNATURE Marion C. Porterfield
acting Deputy Md. Chief Bur. of Vital Sta.
Address Hampstead, Md Date signed 5-14-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83(a)

03826

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 9 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 mos 9 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Alice Bond.

3.(b) Social Security Number:

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 9th - 1872

8. AGE: Years: 75 Months: 9 Days: 22 If less than one day: ____ hrs. ____ min.

9. Birthplace: Fredyrick (Town, county and state)

10. Usual occupation: Sales Lady

11. Industry or business: Store

FATHER 12. Name: Cornelius Bond

FATHER 13. Birthplace: Fredyrick Co

MOTHER 14. Maiden name: Hannah Englar

MOTHER 15. Birthplace: Carroll Co.

16. Informant: Mrs. Martha Grimes

Address: Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 5-1947 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Johnsville, Md

18. Funeral director: D. H. Hartley & Sons

Address: Union Bridge & New Windsor Md.

19. May 2 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2d 1947, at 1-25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1947, to May 2 1947 and that I last saw h[illegible]live on May 2d 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 hrs
Due to: Hypertension	
Due to: Arterio Sclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. A. Gaston M. D. or other

Address: Sykesville Date signed: 5/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03827

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 month, 5 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 607 W. Hamburg Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BLONDELL HEZKIAH BROWN

3.(b) Social Security Number: 220-03-9604

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Lillian Brown
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): June 25, 1921

8. AGE:

Years	Months	Days	If less than one day
25	10	16	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Fireman
11. Industry or business:
FATHER 12. Name: Blondell H. Brown, Sr.
13. Birthplace: Maryland
MOTHER 14. Maiden name: Martha Gross
15. Birthplace: Maryland
16. Informant: Deceased
Address:
17. Burial, cremation, or removal. Which?: Burial Date thereof: May 15/47 (month) (day) (year)
Cemetery or crematory: Calvary
Location: Mt. Calvary Md
18. Funeral director: James A. Hayden
Address: 142 W Hill St
19. (Date rec'd by registrar) 5/11 19 47 Albert R. Swackhamer Deputy Local Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: May 11, 1947, at 12.40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6, 1947, to May 11, 1947 and that I last saw him alive on May 11, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1942
Due to:	
Due to:	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben M. Oman, M.D. (M. D. or other)
Address: Henryton, Md. Date signed: 5/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03828

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs., 2 mons., 19 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 14 yrs., 2 mons., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John T. Callahan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 30, 1860

8. AGE: Years	Months	Days	If less than one day
86	10	9	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business
FATHER 12. Name: unknown
13. Birthplace
MOTHER 14. Maiden name: unknown
15. Birthplace
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12 1947 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Road
18. Funeral director: John C. McGeen
Address: 3600 E. Baltimore St.
19. May 10 1947 (Date rec'd by registrar) C. Henry Edel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1947 at 1:10p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to May 9 1947 and that I last saw him alive on May 9 1947

Immediate cause of death	OURATION
senility	17yrs.
Due to	
Due to	
Other conditions: senile psychosis	17yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D. M.D. or other
Address: Sykesville, Maryland Date signed: 5-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

03829

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Howard B Crawmer

3.(b) Social Security Number 218-07-3996

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma Jane Crawmer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 9- 1866

8. AGE:

Years	Months	Days	If less than one day
78	7	1	..... hrs. ..... min.

9. Birthplace Carroll County Maryland (Town, county, and state)

10. Usual occupation Retired Foreman RR

11. Industry or business Lehigh Portland Cement Co.

FATHER

12. Name John Crawmer

13. Birthplace Maryland

MOTHER

14. Maiden name Mary Elizabeth Mullinix

15. Birthplace Maryland

16. Informant Mrs Emma Jane Crawmer

Address Union Bridge, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12-1947 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location near New Windsor Md

18. Funeral director D.D. Hartzler & Sons

Address Union Bridge & New Windsor, Maryland

19. May 12 1947 (Date rec'd by registrar) C. Eichelman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to May 10 1947

and that I last saw him alive on May 9 1947

	DURATION
Immediate cause of death Chronic Myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Legg M. D. nr other

Address Union Bridge Date signed 5-10-47

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03830

Reg. Dist. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster RD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Denninga

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Winfield

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ella Yohn Cronk

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Dr E D Cronk

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 26-1862

8. AGE: Years	Months	Days	If less than one day
85	4	0	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Williams Yohn

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rachael Owings

MOTHER — 15. Birthplace: Maryland

16. Informant: William Yohn Jr.

Address: Westminster, Maryland RD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28-1947 (month) (day) (year)

Cemetery or crematory: Taylorsville Methodist Cemetery

Location: Taylorsville, Maryland

18. Funeral director: E D Hertzler + Sons

Address: New Windsor + Union Bridge, Md

19. May 27 1947 (Date filed by registrar) E M Farver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1947, at 8:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945, to May 26 1947

and that I last saw h[illegible] alive on May 15 1947

Immediate cause of death	DURATION
Generalized Arteriosclerosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury. Injured at work?

23. SIGNATURE: James T Shorb M. D. or other

Address: Westminster Md Date signed: May 27-47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03831

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatroium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Vienna
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ALBERT SAMUEL DEMBY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec., 24, 1922

8. AGE:

Years	Months	Days	If less than one day
24	5	0	..... hrs. ..... min.

9. Birthplace: Vienna, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Edward Demby
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Alice Parker
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28, 1947 (month) (day) (year)
Cemetery or crematory: Vienna
Location: Dorchester Co., Md.

18. Funeral director: J. J. Trampleb & Son
Address: Fredericksburg, Md.

19. 5/24 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24, 1947, at 6.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan., 21, 1947 to May 24 1947 and that I last saw him alive on May 24, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 5/24/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

03832

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Doyle Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carrie Doyle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or ~~wife~~ Michael A. Doyle
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 18 - 1875

8. AGE: Years	Months	Days	If less than one day
71	9	21	..... hrs. ..... min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)
10. Usual occupation Milliner
11. Industry or business
FATHER 12. Name Michael McCaffrey
13. Birthplace Ireland
MOTHER 14. Maiden name Henrietta Frumke
15. Birthplace Ireland
16. Informant J. Douglas West
Address 4 Doyle Ave Westminster, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof May 12, 1947 (month) (day) (year)
Cemetery or crematory St. Johns Cemetery
Location Westminster, Md.
18. Funeral director H. Bankard & Son
Address Westminster, Md.
19. 5/10 19 47 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1947, at 6.30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 - 1947, to May 9 - 1947
and that I last saw her alive on May 9 - 1947

	DURATION
Immediate cause of death Acute Cardiac Dilatation	6 hrs
Due to Acute Interstitial Nephritis	6 days
Due to Diabetes Mellitus	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Chas R Fouts M.D.
M. D. or other
Address Westminster Md. Date signed 5-10-47

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03833

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 6/19/40

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? Since 6/19/40

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allgany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Fannie Duckworth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1907 (month + day unknown)

8. AGE: Years	Months	Days	If less than one day
40	?	?	hrs. min.

9. Birthplace: Probably Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Thomas Duckworth

13. Birthplace: ?

MOTHER — 14. Maiden name: Linda Belle Duckworth

15. Birthplace: ?

16. Informant: Recrods, Springfield State. Hosp.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6 - 3 - 47 (month) (day) (year)

Cemetery or crematory: Westernport

Location: Westernport, Md.

18. Funeral director: D. L. Boak

Address: Westernport, Md.

19. June 1 1947 (Date rec'd by registrar) C. Henry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1947 at 1 30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1947 to May 31 1947

and that I last saw her alive on May 31 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 mo.
Due to:	
Due to:	
Other conditions: Mental Deficiency (Idiocy)	life

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. (M. D. or other)

Address: Sykesville, Maryland Date signed: 5-31-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03834

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yr., 3 mo., 7 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 3 yr., 3 mo., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Charles Lee Earsom (alias William Earson)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	dicorced

6.(b) Name of husband or wife: Unk—

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 17, 1887

8. AGE: Years	Months	Days	If less than one day
59	5	22	..... hrs. ..... min.

9. Birthplace: Springfield, West Virginia
(Town, county, and state)

10. Usual occupation: Unk—

11. Industry or business

FATHER
12. Name: William F. Earsom
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Mary Neff
15. Birthplace: West Virginia

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 1947 (month) (day) (year)

Cemetery or crematory: Cumberland

Location: Cumberland, Md.

18. Funeral director: Lowis-Stein, Inc.

Address: Cumberland, Md.

19. May 10 1947 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1947, at 8:00p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 10 1944, to May 9 1947

and that I last saw him alive on May 9 1947

Immediate cause of death	DURATION
General Paralysis of the Insane	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D. M. D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed 5-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

03835

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:

County Carroll

City or town Mt. Airy, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred: Home Mt. Airy, Md.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Mt. Airy, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida Marian Engle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Franklin Engle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1855

8. AGE: Years	Months	Days	If less than one day
92	3	17	..... hrs ..... min.

9. Birthplace Kemptown, Frederick Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name John Lewis

13. Birthplace Maryland

MOTHER 14. Maiden name Evelyn Mayberry

15. Birthplace Maryland

16. Informant Mrs. H. L. Nicodemus

Address Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2 1947 (month) (day) (year)

Cemetery or ~~crematory~~ Kemptown

Location Kemptown, Md

18. Funeral director L. B. Beall, Inc.

Address Woodsboro, Md

19. May 31 1947 Thos. D. Snyder

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 29 1947 to May 30 1947 and that I last saw her alive on May 30, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 da
Due to Arterio-Sclerosis	? yrs
Due to Senility	? yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. or other

Address Mt. Airy, Md. Date signed 5/31/47

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

4509

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH:

County Carroll

City or town Carroll Mt Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Taylorsville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Blair

City or town Roaring Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 401 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ruth N. Feather

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	~~Married~~ Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 31, 1907

8. AGE: Years	Months	Days	If less than one day
39	9	29	..... hrs. ..... min.

9. Birthplace Blair Co. Penna.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Blank Book Factory

FATHER 12. Name Austin M. Feather

13. Birthplace Penna

MOTHER 14. Maiden name Matilda Helsel

15. Birthplace Penna.

16. Informant Mr. D. F. Feather

Address 500 Locust St. Roaring Spring Pa.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 6-2-47. (month) (day) (year)

Cemetery ~~or crematory~~ Lutheran Cemetery

Location Newry, Blair Co. Penna

18. Funeral director E. M. Waltz

Address Williamsburg, Pa.

19. May 31 1947 Edna M. Hewitt Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured skull and	
Due to Cerebral Hemorrhage	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/30/47

Where did injury occur? Taylorsville (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Automobile Accident Injured at work? No

23. SIGNATURE James T. Mount Deputy Medical Examiner
M. D. or other

Address Westminster Md Date signed 5/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46e

03836

Reg. Dist. No. 72

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster, R.D. 2 Nr Union Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster, R.D. 2, Nr Union Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Issadore Rahamma Feeser

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Orestus W. Feeser

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Jan. 18 1870

8. AGE:

Years	Months	Days	If less than one day
77	3	21	hrs. min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Housewife

FATHER
12. Name: Josiah Kump
13. Birthplace: Carroll County, Md.

MOTHER
14. Maiden name: Mary Elizabeth Reinecker
15. Birthplace: Carroll County, Md.

16. Informant: Bertha L. Feeser
Address: Westminster, Md. R.D.2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11 1947 (month) (day) (year)

Cemetery or crematory: St. Mary's Union Cemetery

Location: Silver Run, Md.

18. Funeral director: F. W. Littlestown Son

Address: Littlestown, Pa.

19. May 10th 1947 (Date rec'd by registrar) Calvin T. Bankert, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 1947 to May 9 1947 and that I last saw her alive on May 8 1947

Immediate cause of death	DURATION
Intestinal obstruction	5 Days
Due to: Cancer of breast	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reece Wilkens M. D. or other

Address: Westminster Date signed: 5/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03837

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 17 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 523 W. Hoffman Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM GAMBLE

3.(b) Social Security Number: 212-12-9934

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Carrie Gamble
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): Sept., 1, 1916

8. AGE: Years	Months	Days	If less than one day
30	8	12	hrs. min.

9. Birthplace: Hanover, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Jane Gamble
15. Birthplace: Prince George's County, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15 47 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Baltimore
18. Funeral director: A. Lothus Halstead
Address: 918 Druid Hill Ave

19. 5/13 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1947 at 8.40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26, 1946 to May 13, 1947 and that I last saw him alive on May 13, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 14, 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Kuman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 5/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83b

03838

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~all~~ 3 1/2 years

Hospital, Institution, or street address where death occurred: Pennfort Nursing Home

How long in hospital or institution? 3 1/2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Woodsboro Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war ....

3.(a) FULL NAME Ida Virginia Geesey

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	~~Married~~ Widow

6.(b) Name of husband or wife John A. Geesey

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1859

8. AGE: Years	Months	Days	If less than one day
87	6	29	....hrs. ....min.

9. Birthplace Near Frederick Fred Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Retired

FATHER
12. Name Frederick Bland
13. Birthplace Germany

MOTHER
14. Maiden name Mary Ann Schaeffer
15. Birthplace Fred Co. Md.

16. Informant Mrs. G. B. Crist

Address Frederick, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May (month) 27 (day) 47 (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Frederick Co. Md.

18. Funeral director M. C. Stahlman & Son

Address 106 E. Church St. Frederick Md.

19. 5/26 1947 (Date rec'd by registrar) H. J. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 2:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 1945, to May 24 1947

and that I last saw h... alive on May 24 1947

Immediate cause of death	DURATION
(a) Cerebral Thrombosis	2 wks
Due to (b) Coronary Arteriosclerosis	3 years
Due to (c) ...	...
Other conditions Congestive Heart Failure	1 mo

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE L. G. Crouse M. D. or other

Address Westminster Date signed 5/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03839

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 6 days
Hospital, Institution, or street address where death occured: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1351 N. Stockton Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARTHA GIBSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 23, 1920

8. AGE: Years	Months	Days	If less than one day
26	4	20	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:
FATHER 12. Name: Will Carroll
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Finney Carroll
MOTHER 15. Birthplace: Maryland.
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal, Which?) Date thereof 5-17-47 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Baltimore City
18. Funeral director: Geo. G. Kelson
Address: 1303 Restman. St
19. 5/13 (Date rec'd by registrar) 19 47 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 19 47, at 9.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7, 1946 to May 13, 1947 and that I last saw h... er alive on May 13, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Chelsea W. Swan M. D. M. D. or other
Address: Henryton, Md. Date signed: 5/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

CERTIFICATE OF DEATH

03840

Reg. Dist. No. 78

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Newport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Newport
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural → New Windsor
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Louis E. Graham

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of ~~husband or~~ wife: Vennie Graham
~~deceased~~

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1880

8. AGE: Years	Months	Days	If less than one day
66	7	3	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Thomas Graham
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ellen Brent
15. Birthplace: Virginia

16. Informant: Mrs. Grace Hopkins
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 5-19-47 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Coors Corner, Carroll Co. Md.

18. Funeral director: C. M. Wolfe

Address: Winfield Md

19. May 18 1947 (Date rec'd by registrar) E. M. Farver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1947, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to May 16 1947 and that I last saw h~~im~~ alive on May 14 1947

Immediate cause of death: Chronic Endocarditis with Cardiac Arrest — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. M. Van Poole
M. D. or other

Address: Mt Airy Md Date signed: 5-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03841

Reg. Diat. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Westminster - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 56 years

Hospital, Institution, or street address where death occurred:

102 Liberty St Ext'd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. 102 Liberty St. Ext'd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry Mencher Helwig

3.(b) Social Security Number 220-01-3150

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Alexia Cook Helwig

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1870

8. AGE: Years	Months	Days	If less than one day
76	7	3	..... hrs. ..... min.

9. Birthplace Near Westminster Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Hardware Travelers (Clerk)

11. Industry or business

FATHER

12. Name George A. Helwig

13. Birthplace Maryland

MOTHER

14. Maiden name Selena Mencher

15. Birthplace Gettysburg Pa. (?)

16. Informant Mrs. Harry M. Helwig

Address 102 Liberty St. Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 '47 (month) (day) (year)

Cemetery or ~~crematory~~ Meadow Branch

Location near Westminster Md

18. Funeral director C. E. Myers Jr.

Address Westminster Md

19. 5/29 1947 (Date rec'd by registrar) L. ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947, at 9.17 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to May 28 1947

and that I last saw him alive on May 27- 1947

Immediate cause of death

My carditis (chr.)

Nephritis (chr.)

Due to

Due to

Other conditions Uremia

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jennette, M.D.

M. D. or other

Address Westminster Md Date signed 5-29-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03842

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 4 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ROSALEE AGNES HENSON

3.(b) Social Security Number: 578-28-7039

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 13, 1919

8. AGE: Years	Months	Days	If less than one day
28	1	0	..... hrs. ..... min.

9. Birthplace: Calvert County, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Lawrence Henson
13. Birthplace: Adalina, Md.

MOTHER
14. Maiden name: Myrtle Wilson
15. Birthplace: Baltimore, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal) Date thereof 5 16 1947 (month) (day) (year)
Cemetery or crematory Arbutus Mem Park
Location

18. Funeral director: Mrs Katie R Williams
Address 322 N. Schroeder St

19. 5/13 19 47 (Date rec'd by registrar) Albert R Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1947, at 2.50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9, 1947, to May 13, 1947 and that I last saw her alive on May 13, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Rosalee Henson, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 5/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03843

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Most of her life
Hospital, Institution, or street address where death occurred: Manchester Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3 miles from West Minster on Manchester Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Ann Keesey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Adam M. Keesey
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Oct 2. 1869

8. AGE: Years: 77 | Months: 7 | Days: 16 | If less than one day: ... hrs. ... min.

9. Birthplace: Adams Co. Penna.
(Town, county, and state)

10. Usual occupation: House-wife

11. Industry or business:

FATHER
12. Name: Jonas Cayer
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Mary Law
15. Birthplace: York Co. Penna.

16. Informant: Mr. Adam M. Keesey
Address: Westminster Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21/47 (month) (day) (year)

Cemetery or crematory: Meadow Branch
Location: Near Westminster, Md.

18. Funeral director: J. E. Myers & Son
Address: Westminster Md.

19. 5/19/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May. 18 1947, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1946, to May. 18 1947
and that I last saw h.er alive on May. 18 1947

Immediate cause of death	DURATION
Coronary Thrombosis	8 hrs.
Due to: Coronary Arterio-Sclerosis	14 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Porter, M.D. (M. D. or other)
Address: Hampstead Md. Date signed: 5-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03844

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 5 months, 13 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 6 years, 5 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 463 Brunswick Street
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: LENA S. KEIL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William F. Keil

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 23, 1889

8. AGE: Years	Months	Days	If less than one day
57	9	22	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: Frederic Schlutter
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Dorothy Bain
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-19-47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Md.

18. Funeral director: George L. Schwab

Address: 2101 Fredrick Avenue

19. May 16 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15th 1947, at 3:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1st 1942, to May 15th 1947 and that I last saw her alive on May 15th 1947

Immediate cause of death	DURATION
Coronary occlusion	3 minutes
Coronary disease	
Due to: generalized arteriosclerosis	
and arterial hypertension	6 years
Due to:	
Other conditions: Manic-depressive psychosis,	
manic phase	29 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Irene Hohenman, M.D.
M. D. or other

Address: Springfield State Hospital Date signed: 5-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of birthdate shown on Film G110 6/18/47 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03845

13t BC

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 17 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1724 W/ Lexington St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIS KING

3.(b) Social Security Number: 211-10-5139

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mary E. King
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): March 1, ~~1893~~ 1894

8. AGE: Years ~~53~~ ~~54~~ | Months 2 | Days 30 | If less than one day: hrs. min.

9. Birthplace: Prince Geo's County, Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Ephrian King
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Hayes
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/4/47 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location:

18. Funeral director: Mrs Katie K Wilfong
Address: 322 n Schroder street Baltimore Md

19. 5/31 19 47 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31, 19 47, at 2.50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14, 19 47, to May 31, 19 47 and that I last saw him alive on May 31, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W Fuson, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 5/31/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03846

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 4/14/37

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or Institution? Since 4/14/37

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3529 Reisterstown Road, Baltimore, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Celia Levy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4/6/03

8. AGE: Years	Months	Days	If less than one day
44	1	17	hrs. min.

9. Birthplace: Chicago, Illinois
(Town, county, and state)

10. Usual occupation: Factor Worker

11. Industry or business: ?

FATHER
12. Name: Harry Levy
13. Birthplace: Russia

MOTHER
14. Maiden name: Sarah ?
15. Birthplace: Russia

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Buried (Burial, cremation, or removal, Which?) Date thereof 5-25-47 (month) (day) (year)
Cemetery or crematory: Adel - Shalom Cem.
Location: Balto. Md.

18. Funeral director: Jack Lewis, Inc.
Address: 1439 E. Balto. St.

19. May 23 1947 (Date rec'd by registrar) C. Henry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/23 1947 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/8 1947 to 5/23 1947 and that I last saw h. 34 alive on 5/22 1947

Immediate cause of death	DURATION
Cancer of the Ovary	unknown
(Multilocular Cyst of the Ovary)	Discovered 2-8-47
Due to:	
Other conditions: Schizophrenia, Paranoid type	14 years
(Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 5/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03847

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. 79 Liberty St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marion Marcine Lippy

3.(b) Social Security Number 216-22-9860

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife George E. Lippy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 29 - 1875

8. AGE: Years	Months	Days	If less than one day
72	-	18	..... hrs. ..... min.

9. Birthplace Manchester, Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Attendant

11. Industry or business Chiropractic office

FATHER 12. Name George W. Eckhart

13. Birthplace Manchester, Md.

MOTHER 14. Maiden name Rachael Frank Foster

15. Birthplace Manchester, Md.

16. Informant William H. Myers

Address 79 Liberty St, Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20, 1947 (month) (day) (year)

Cemetery or crematory Kriders Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 5/19/47 (Date rec'd by registrar) 19 C. Ray Fogle Dep Reg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1947, at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1947, to May 17, 1947 and that I last saw her alive on May 17, 1947

	DURATION
Immediate cause of death Acute Cardiac Dilatation	1½ hrs
Due to Chronic Myocarditis	5 yrs
Due to Arterio Sclerosis	8 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Oscar R. Fonts MD M. D. or other

Address Westminster Md. Date signed 5-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for addition of sex, color and maritial status shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

FILE No. G 110 JUN 20 1947

CERTIFICATE OF DEATH

03848

Reg. Diat. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 121 E. Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles M. Miller

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Laura B. Crawford
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26 1858

8. AGE: Years 89 | Months 3 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace Carroll Co. Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Nelson Miller
13. Birthplace Md.

MOTHER 14. Maiden name Christina Forsythe
15. Birthplace Md.

16. Informant Albert Miller
Address 121 E. Main Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13-1947 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18. Funeral director H. Bankard & Son
Address Westminster Md.

19. 6/12 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 1947 at 10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1st 1946 to May 10th 1947 and that I last saw h... alive on May 6th 1947

	DURATION
Immediate cause of death Chronic Myocarditis	Several years
Due to Coronary sclerosis	5 or 6 years
Due to	
Other conditions Senility	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Billingslea M.D.
M. D. or other
Address Westminster Md. Date signed 5-10-47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

03849

CERTIFICATE OF DEATH

Reg. Diat. No. 81

1. PLACE OF DEATH:

County Carroll

City er tewn Keymar
(If outside city or town limits, write RURAL and give nearest town)

How long in abeve place of death? 9 yrs.

Hospital, Institutien, er street address where death occurred:

How long in hospital er institutien?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland Ceuoty Carroll

City or town Keymar
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harrison William Mort

3.(b) Social Security Number 220-10-5227

4. Sex	5. Color er race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name et husband or wife Nettie E. Eyler

6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1889

8. AGE: Years 57 | Months 7 | Days 0 | If less than ene day ... hrs. ... min.

9. Birthplace New Midway, Fredk. Co., Md.
(Town, county, and atate)

10. Usual eccupatien Carpenter

11. Industry or business

FATHER
12. Name Franklin Mort
13. Birthplace Md.

MOTHER
14. Maiden name Margaret Claybaugh
15. Birthplace Md.

16. Informant Mrs. Nettie E. Mort
Address Keymar, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereef May 30, 1947 (month) (day) (year)

Cemetery or crematory Haugh's Cemetery

Lecatien near Ladiesburg, Md.

18. Funeral director Powell & Hartzler

Address Woodsboro, Md.

19. May 28, 1947 (Date rec'd by registrar) Richards Deputy Registrar

MEDICAL CERTIFICATION E. S. T.

20. DATE OF DEATH May 27, 1947, at 11:20 P M

21. I CERTIFY that death occurred on the date abeve stated; that I attended deceased frem May 27, 1947, to same, 19—
and that I last saw h.i.m. alive en May 27, 1947

Immediate cause of death cardiac and respiratory failure — DURATION

Due te Cerebral hemorrhage — 1 wk.

Due te

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or hemicide none Date of

Where did injury occur? (City or town) (County) (State)

Injured at heme, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE W. R. Bradley, D.

M. D. or other

Address Taneytown Md Date signed 5/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03850

Reg. Dist. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs 6 mos 29 da

Hospital, institution, or street address (where death occurred) Springfield State Hospital

How long in hospital or institution? 7 yrs 6 mos 29 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. Unk

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Catherine P Flagging

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE:

Years	Months	Days	If less than one day
80			..... hrs. ..... min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual occupation

11. Industry or business Keeping Boarding House

FATHER 12. Name Charles P Flagging

13. Birthplace Germany

MOTHER 14. Maiden name Catherine Schilling

15. Birthplace Germany

16. Informant Miss Mary Schuller

Address 550 W Fayette St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-18-47 (month) (day) (year)

Cemetery or crematory London Park Cem.

Location Balto Md.

18. Funeral director John W Leech

Address 5311 Edmondson Ave.

19. May 18 1947 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th 1947, at 1-30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 1946 to May 18th 1947

and that I last saw h.er alive on May 18th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 hrs
Due to	
Due to Arterio Sclerosis Hypertension	12 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J J Hastings MD M. D. or other

Address Sykesville Md Date signed 5/18/47

Evidence for the addition of information concerning residence of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILM No. G 110 JUN 16 1947

848

03851

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yr., 1 mo., 28 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 17 yr., 1 mo., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Balto.
City or town: Towson (If outside city or town limits, write RURAL and give nearest town)
Street No.: Sheppard-Pratt (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Curtis S. Price

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 10, 1872

8. AGE: Years	Months	Days	If less than one day
74	8	21	hrs. min.

9. Birthplace: California (Town, county, and state)
10. Usual occupation: student
11. Industry or business

FATHER
12. Name: Curtis E. Price
13. Birthplace: Ohio

MOTHER
14. Maiden name: Frances Shaw
15. Birthplace: Canada

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/3/47 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cem.
Location: Towson, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 6/2 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1947, at 5:00P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to May 31 1947 and that I last saw h.im alive on May 31 1947

Immediate cause of death	DURATION
Senility	10 yrs.
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic type	54 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
M.D. or other
Address: Springfield State Hospital, Sykesville, Maryland Date signed: 5-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

03852

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 3 mos 6 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 3 mos 6 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Rhodes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed.

6.(b) Name of husband or wife: Unk.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE: Years: 73 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Unk.

11. Industry or business:

FATHER — 12. Name: Edgar Airey

13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Mrs. Helen Stevenson

Address: Glen Burnie Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: May 13, 1947 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Balto. Md.

18. Funeral director: William Cook, Inc.

Address: 1217 St Paul St. Balto. Md.

19. May 10 1947 (Date rec'd by registrar) C. Henry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9th 1947 at 8-15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jul 2 1945 to May 9th 1947 and that I last saw h.. alive on May 9th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 wks
Due to:	
Due to: Cerebral Arterio Sclerosis ?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. J. Gaston M.D. (M. D. or other)

Address: Sykesville Md. Date signed: 5/9/47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03853

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 93 Liberty St. Extended
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Blanche Mildred Robertson

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Walter E. Robertson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 9, 1881

8. AGE: Years	Months	Days	If less than one day
65	8	3	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Elias Flater
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie E. Phillips
15. Birthplace: Maryland

16. Informant: Joshua M. Monath
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5/14/47 (month) (day) (year)
Cemetery or crematory: Sandy Mount Cemetery
Location: Sandy Mount, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.
19. 5/13/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 19 47, at 12:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 – 19 47, to May 12 – 19 47
and that I last saw h alive on May 11 – 19 47

	DURATION
Immediate cause of death: Cerebral Embolism	
Dilatation	6 hrs
Due to: Cerebral Hemorrhage	3 days
Due to: Chronic Interstitial Nephritis	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward R Foutz MD M. D. or other
Address: Westminster Md Date signed: 5-12-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

03854

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Years 9 months

Hospital, Institution, or street address where death occurred: 113 E. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 E. Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William George Roch

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	widowed

6.(b) Name of husband or wife Kate Bell Roch

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10. 1861

8. AGE: Years 85 | Months 9 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace Liverpool England
(Town, county, and state)

10. Usual occupation accountant, retired

11. Industry or business

FATHER 12. Name Samuel Roch

FATHER 13. Birthplace England

MOTHER 14. Maiden name Alicia Custins

MOTHER 15. Birthplace England

16. Informant Wm. E. Roch

Address 113 E. Main St. Westminster Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 18. 47 (month) (day) (year)

Cemetery or crematory Mansfield Cemetery

Location Columbia N. J.

18. Funeral director J. E. Myers Jr.

Address Westminster, Md.

19. 6/31 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47 at 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 46 to May 30 19 47

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Generalized Arteriosclerosis	4 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE James T Marsh M. D. or other

Address Westminster Md Date signed May 31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 03855

CERTIFICATE OF DEATH

Reg. Diat. No. [illegible]

1. PLACE OF DEATH:

County: Carroll

City or town: Woodbine Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Francis S. Rodgers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Emma Rodgers

6.(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): April 29, 1867

8. AGE:

Years	Months	Days	If less than one day
80	0	4	hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: James Rodgers

13. Birthplace: Maryland

MOTHER 14. Maiden name: Margaret Slick

15. Birthplace: Maryland

16. Informant: Mrs. Helen Haines

Address: Woodbine Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-6-1947 (month) (day) (year)

Cemetery ~~or crematory~~: Morgan Chapel

Location: Woodbine, Carroll Co. Md.

18. Funeral director: C. H. Wells

Address: Winfield Md.

19. May 5 1947 (Date rec'd by registrar) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5, 1947 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26, 1947 to May 4 1947 and that I last saw h[illegible] alive on May 3 1947

Immediate cause of death	DURATION
Cerebral apoplexy	1 wk
Due to: Hypertension	? yrs
Due to: Arteriosclerosis	? yrs
Other conditions: Chr. Interstitial nephritis and Chr. uremia	? months

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other

Address: Mt Airy Md Date signed 5/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03856

106a

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
27 Ridge Rd.
How long in hospital or institution? 3 yrs - above address

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 27 Ridge Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME: GEORGE ALBERT L. SALTER

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian M. Salter
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 16, 1868

8. AGE: Years	Months	Days	If less than one day
78	9	9	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: retired
11. Industry or business

FATHER
12. Name: Theodore E. Salter
13. Birthplace: Philadelphia, Pa.

MOTHER
14. Maiden name: Harriette A. Yearyley
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Lillian M. Salter
Address: 27 Ridge Rd., Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/27/47 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. May 26 19 47 (Date rec'd by registrar) A. W. Jessup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25- 19 47 at 8 a- M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 30. 19 47, to May 24 19 47 and that I last saw h... alive on May 24- 19 47

Immediate cause of death: acute Pulmonary Nephritis — DURATION: 3 wks

Due to: acute Bronchitis — 2 days

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas R Foutz M.D.
M. D. or other
Address: Westminster Md. Date signed 5-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

03857

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George R. Sauble

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Irene Reifsnider Sauble

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 9, 1875

8. AGE: Years	Months	Days	If less than one day
71	11	11	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Own farm

FATHER — 12. Name: William Sauble

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Ann Geiger

15. Birthplace: Maryland

16. Informant: Mrs. George R. Sauble

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23, 1947 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Taneytown, Md.

18. Funeral director: C. O. Fuss & Son

Address: Taneytown, Md.

19. May 23 1947 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20th. 1947, at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1st. 1947 to May 20th 1947 and that I last saw him alive on May 17th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	a few minutes
Due to: Arteria Sclerosis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. M. Benner M.D. M. D. or other

Address: Taneytown Maryland Date signed: May 20th 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03858

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs. 1 mo's. 11 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 917 N. Bond Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOSEPH GODFREY SIMMONS

3.(b) Social Security Number: 217-03-0378

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married (Sep)

6.(b) Name of husband or wife: Viola Simmons
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): November 25, 1903

8. AGE:

Years	Months	Days	If less than one day
43	5	11	....hrs. ....min.

9. Birthplace: Norfolk, Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: John Simmons
13. Birthplace: Virginia

MOTHER
14. Maiden name: Martha Pitt
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19-1947 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cem
Location:

18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley Ave

19. 5/16 (Date rec'd by registrar) 19 47 Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 19..., at 47 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 25, 19 40 to May 16, 19 47
and that I last saw him alive on May 16, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M. D.
M. D. or other
Address: Henryton, Md Date signed 5/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03859

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 9 mos., 2 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES SMITH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 26, 1894

8. AGE: Years: 53 | Months: 2 | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Lee Smith
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal: Which?) Date thereof 6-4-47 (month) (day) (year)
Cemetery or crematory: St. Luke's Cem.
Location: Lyndonville, Md.

18. Funeral director: C. Harry Wees
Address: Lyndonville, Md.

19. May 29, 1947 (Date rec'd by registrar) Albert R. Swankhouser Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29, 1947, at 2:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27, 1945, to May 29, 1947 and that I last saw h... im alive on May 29, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Doreen W. Fuson, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 5-29-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 03860

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 11 mo's., 1 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 702 Warner Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RICHARD HARRISON SMITH

3.(b) Social Security Number: 216-10-3771

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Carrie Smith
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 20, 1888

8. AGE: Years	Months	Days	If less than one day
59	0	25	hrs. min.

9. Birthplace: Painter, Va.
(Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business:
FATHER 12. Name: George Smith
13. Birthplace: Virginia
MOTHER 14. Maiden name: Unknown
15. Birthplace: Virginia
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 May 19 1947 (month) (day) (year)
Cemetery or crematory: Mount Calvary Cemetery
Location: Anne Arundel County, Md.
18. Funeral director: Joseph A. Sivley Funeral Home
Address: 66 West Baltimore and
19. 5/15 (Date rec'd by registrar) 19 47 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15, 1947 at 1.00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14, 1945 to May 15, 1947 and that I last saw him alive on May 15, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Innes, M.D. M. D. or other
Address: Henryton, Md. Date signed: 5/15/47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03861

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Mount Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mount Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: DORSEY WILBUR SPURRIER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Dora M. Ball
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): August 1, 1888

8. AGE: Years	Months	Days	If less than one day
58	9	2	hrs. min.

9. Birthplace: Frederick County Maryland (Town, county, and state)
10. Usual occupation: Retired Railroad Employee
11. Industry or business

FATHER
12. Name: John H. Spurrier
13. Birthplace: Frederick County Maryland

MOTHER
14. Maiden name: Laura V. Beall
15. Birthplace: Frederick County Maryland

16. Informant: Mrs. Dora Spurrier
Address: Mount Airy, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/6/47 (month) (day) (year)
Cemetery or crematory: Mount Olivet Cemetery
Location: Frederick, Maryland

18. Funeral director: M. R. Etchison and Son
Address: Frederick, Maryland

19. 5/6/ 47 Thos. D. Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3rd, 1947, at 10:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to May 3 1947 and that I last saw h.. alive on May 3 1947

Immediate cause of death	DURATION
Chr. Cardiac decompensation	18 mo
Due to: Chr. Myocarditis	? yrs
Due to:	
Other conditions: Urinary retention	9 hrs
Due to Prostatic hypertrophy	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Stanley Grabill M. D.
M. D. or other
Address: Mount Airy, Maryland Date signed: 5-5-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

03862

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, institution, or street address where death occurred: 39 Union St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 39 Union St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Joseph M. Sputrell

3. (b) Social Security Number: 220-07-7129-B

4. Sex: M. | 5. Color or race: Col. | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Laura Sputrell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 25, 1862 (?)

8. AGE: Years: 84 | Months: 8 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Westminster Carroll Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: fertilizer plant

FATHER 12. Name: Jacob Sputrell

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Eliza Jane Black

MOTHER 15. Birthplace: Carroll Co. Md.

16. Informant: Mrs. Robert Sputrell

Address: 39 Union St. Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1 (month) 45 (day) (year)

Cemetery or crematory: Ellowood Cem

Location: near Westminster Md.

18. Funeral director: J. S. Myers D.

Address: Westminster Md.

19. 5/29 (Date rec'd by registrar) 1945 (Registrar)

MEDICAL CERTIFICATION 2 A.M.

20. DATE OF DEATH: May 28 1945, at ~~P.M.~~ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1945, to May 28 1945

and that I last saw him alive on May 28 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 hrs
Due to: Chronic Interstitial nephritis	4 yrs
Due to: Arteriosclerosis	8 yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas R Foutz MD M.D. or other

Address: Westminster Md. Date signed: 5-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Diat. No. 0379

1. PLACE OF DEATH:
County Carroll
City or town Keymar
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Keymar
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Mrs. Laura V.E. Stoner

3. (b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Thomas M.A. Stoner
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 25, 1849

8. AGE: Years	Months	Days	If less than one day
98	2	24	hrs. min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name William H. Bowman
13. Birthplace Md
MOTHER 14. Maiden name Mary A. Hyder
15. Birthplace Md
16. Informant Miss Anna Bruchey
Address Keymar, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1947 (month) (day) (year)
Cemetery or crematory Bever Dam
Location Nr. Union Bridge, Md.
18. Funeral director C.O. FUSS & SON
Address Taneytown, Md.
19. May 20 1947 (Date rec'd by registrar) Fanny M. Keiss Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947 at 7:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to May 19 1947
and that I last saw h... alive on May 18 1947
Immediate cause of death Hypertensive Cardio Vascular Renal Disease — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Carroll E. Eastburn M. D. or other
Address Wolfsville, Md. Date signed May 19, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

03863

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 67 W. Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 67 W. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Grace Stultz

3.(b) Social Security Number: 215-14-1343

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~: Roger Stultz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 4 - 1912

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
35	1	16		

9. Birthplace: Carroll County, Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: George W. Gaver
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Gaver
15. Birthplace: Maryland

16. Informant: Roger Stultz
Address: 67 W. Main St. Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23-1947 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Taylorsville, Md

18. Funeral director: D. D. Hartsfield & Sons
Address: Union Bridge & New Windsor Md.

19. May 22 1947 (Date rec'd by registrar) Clay Fogle Registrar
Dep. Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1947, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1947, to May 20 1947
and that I last saw h.. alive on May 19 1947

Immediate cause of death	DURATION
Cerebral Embolism	
Due to: Chronic Endocarditis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. H. Rigg M. D. or other
Address: Union Bridge Md. Date signed: 5-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MAY 22 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46c

03864

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha Marie Stultz

3.(b) Social Security Number 213-03-0416

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Malcolm C. Stultz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 5, 1917

8. AGE: Years	Months	Days	If less than one day
30	0	26	..... hrs. ..... min.

9. Birthplace Thurmont, Frederick Co., Md.
(Town, county, and state)

10. Usual occupation Sewing machine operator

11. Industry or business Rubber factory

FATHER
12. Name Raymond Eichelberger
13. Birthplace Maryland

MOTHER
14. Maiden name Ruth Bell
15. Birthplace Maryland

16. Informant Mr. Malcolm Stultz
Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 5, 1947 (month) (day) (year)

Cemetery or crematory Reformed Cemetery

Location Taneytown, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. May 5 1947 (Date rec'd by registrar) Athel M Mehring Registrar

MEDICAL CERTIFICATION E.S.T.

20. DATE OF DEATH May 1 1947, at 6:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1947, to May 1 1947

and that I last saw her alive on April 25 1947

	DURATION
Immediate cause of death Generalized Carcinomatosis	
Primary site: sigmoid [5/2/47 - alec]	
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations generalized carcinomatosis

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE W P Bradley, Jr. M. D. ~~or other~~

Address Taneytown Md Date signed 5-1-47

M

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VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03867

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3006 Seamon Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DOROTHY MAE TILLMAN

3.(b) Social Security Number: 146-09-5942

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Willie Tillman
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): March 23, 1919

8. AGE: Years	Months	Days	If less than one day
28	1	18	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: James Harris
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mattie Herd
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16-47 (month) (day) (year)
Cemetery or crematory: mt Calvery
Location: Arundel A A
18. Funeral director: Daniel Brown & Son
Address: 108 W mont gomery St

19. 5/11 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 19 47, at 11.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 19 47, to May 11, 19 47 and that I last saw her alive on May 11, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 24 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Barker W Hyman, M D
M. D. or other
Address: Henryton, Md. Date signed: 5/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03865

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rhoda May Trump.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Harry H Trump.
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Aug 24 - 1877

8. AGE:

Years	Months	Days	If less than one day
69	8	29	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: George W Gross
13. Birthplace: Maryland
MOTHER 14. Maiden name: Nancy Bricon
15. Birthplace: Maryland
16. Informant: Harry H Trump
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26/47 (month) (day) (year)
Cemetery or crematory: Mullen
Location: Carroll Co Md
18. Funeral director: Edw C Tipton
Address: Hampstead Md
19. May 25 1947 (Date rec'd by registrar) Mrs. H. P. S. Demuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1947, at 11:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 1947, to May 23 1947
and that I last saw h.er alive on May 22 1947

	DURATION
Immediate cause of death: Hypertension	General mos.
Myocardial degeneration	
& Decompensation	
Due to: Arterio Sclerosis	
(General)	
Due to: Obesity	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wyland Speicher M. D. or other
Address: Westminster Md Date signed: 5/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03868

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs 7 mo 10 da

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? 9 yrs 7 mo 10 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Carroll

State: Md. County: Frederick

City or town: Taneytown Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ida Ann Wachter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Louis J. Wachter

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan 1st 1870

8. AGE: Years 74 | Months 4 | Days 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick Co (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER 12. Name: Andrew Jackson Alfaugh

13. Birthplace: Frederick Co

MOTHER 14. Maiden name: Miranda Ogle

15. Birthplace: Frederick Co

16. Informant: Luther Zimmerman

Address: Taneytown Md

17. Burial (Burial, cremation, or removal: Which?) Date thereof: May 18-1947 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Frederick Md

18. Funeral director: Powell & Hartzler

Address: Woodsboro & Libertytown, Md.

19. May 15 1947 (Date rec'd by registrar) C. Harry Weaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15th 1947, at 7:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1937, to May 15 1947 and that I last saw h[illegible] alive on May 16th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 wks
Due to: Chronic Nephritis	15 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Weston M.D. M.D. or other

Address: Sykesville Md Date signed: 5/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03869

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: 9 months, 24 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 Pleasant Courtt
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SPENCER WILSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 1, 1876

8. AGE: Years: 71 Months: 1 Days: 25 If less than one day: hrs. min.

9. Birthplace: Lancaster County, Va.
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business:

FATHER
12. Name: Henry Wilson
13. Birthplace: Lancaster County, Va.

MOTHER
14. Maiden name: Minnie Jackson
15. Birthplace: Lancaster County, Va.

16. Informant: Deceased
Address:

17. Burial, cremation, or removal. Which?: Burial Date thereof: 5/29/47 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extend
18. Funeral director: Mrs. Chas. E. Hicks
Address: 45 Northwest St. Anne Md.

19. 5/26 19 47 (Date rec'd by registrar) Albert R. Saunders Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26, 19 47 at 6.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 2, 19 46 to May 26, 19 47 and that I last saw him alive on May 26, 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1946
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan M. D.
N. D. or other
Address: Henryton, Md. Date signed: 5/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03870

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Rural, Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs., 6 mo., 14 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 4 yrs., 6 mo., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County .....
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 933 Fell Street
(If rural, give LOCATION)
2.(a) If veteran, name war ..... ✓

3.(a) FULL NAME Stanislaus (Stanley) Yurski

3.(b) Social Security Number 213-01-0819

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Katherine Yurski
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 8, 1879

8. AGE: Years	Months	Days	If less than one day
67	11	22	..... hrs. ..... min.

9. Birthplace Poland
(Town, county, and state)
10. Usual occupation laborer
11. Industry or business

FATHER
12. Name Alexander Yurski
13. Birthplace Poland

MOTHER
14. Maiden name Anna Zelkowski
15. Birthplace Poland

16. Informant Springfield State Hospital records
Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-5-47 (month) (day) (year)
Cemetery or crematory Holy Rozary
Location Baltimore Co. Md.
18. Funeral director George A. Weber
Address 705 So Conn st

19. May 2 1947 (Date rec'd by registrar) R. W. Hebron Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947 at 12:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to May 1 1947 and that I last saw him alive on April 30 1947

Immediate cause of death	DURATION
General Paralysis of the Insane	6 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D.
Address Springfield State Hospital Sykesville, Maryland M. D. or other
Date signed 5-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs 11 mo 9 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 16 yrs 11 mo. 9 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2304 Boston St. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Joseph Bukowski Zukowski **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 27 - 1907

8. AGE: Years: 40 Months: Days: 15 If less than one day: hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: not any

11. Industry or business:

FATHER — 12. Name: James Bukowski

13. Birthplace: Poland

MOTHER — 14. Maiden name: Lena Pozniak

15. Birthplace: Colorado

16. Informant: Mrs Lena Bukowski

Address: 2304 Boston St Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16/47 (month) (day) (year)

Cemetery or crematory: Holy Rosary

Location: Baltimore

18. Funeral director: Fred W. Ozarzuski

Address: 1930 Eastern Ave

19. 5/13/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12th 1947, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3d. 1930 to May 12 1947

and that I last saw h. alive on June 12th 1947

Immediate cause of death	DURATION
Bronchopneumonia	5 da
Due to: Gangrene of R foot	6 mos
Due to:	
Other conditions: Epilepsy	36 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed 5/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M